Gilliam County Community Advisory Council
Community Health Improvement Plan

OVERARCHING PRIORITY ISSUE AREAS

THERE WERE FOUR AREAS THAT WERE PRIORITIZED THROUGH THE COMMUNITY HEALTH ASSESSMENT PROCESS:

1. **MENTAL HEALTH**
2. **ORAL HEALTH EDUCATION/PROMOTION**
3. **PATIENT CENTERED PRIMARY CARE HOME (PCPCH)**
4. **INCENTIVE MEASURES (IM)**

1. Mental Health

SPECIFIC PROBLEMS IDENTIFIED:

1. Stigma associated with mental health
2. Elderly depression
3. Lack of exercise opportunities

STRATEGIES TO REDUCE MENTAL HEALTH STIGMA/ELDERLY DEPRESSION

1.1 ***Outreach & Media Campaign:***

1. Newsletter, posters, postcards that focus on depression and anxiety
2. Combine efforts with the Suicide Awareness For Everyone group (SAFE)*
3. Team with community partners to conduct Mental Health First Aid (MHFA) trainings

MEASURABLE PROJECT OBJECTIVES AND METRIC FOR OUTREACH & MEDIA CAMPAIGN:

1) Number of newsletters, posters, and postcards
2) Number of briefings with the press
3) Number of MHFA trainings
    a. Number of attendees

1.2 ***Social Support and Community Connectedness for Elderly Population-Senior Citizens:***

1. Senior Lunch presentations in Condon and Arlington to increase knowledge and awareness of risk factors and resources
2. Availability of counselors at Senior Lunches through possible collaboration with the Older Adult Behavioral Health Initiative of Greater Oregon Behavioral Health (OABHI- GOBHI)
3. Work on Medicare payment problem to allow Community Counseling Solutions (CCS) to increase availability (i.e. waive fees for those without Medicaid)
4. Mobile mental health services including groups and individual counseling to seniors (i.e. presence at Summit Springs)

MEASURABLE PROJECT OBJECTIVES AND METRIC FOR SOCIAL SUPPORT AND COMMUNITY CONNECTEDNESS:

1) Number of senior lunch presentations
2) Number of senior lunches with counselor present
   a. Interviews with Senior Citizens
   b. Frequency of one-on-one interactions with the community
3) Number of seniors that receive services from CCS with fees waived
4) Number of mobile mental health clinics
   a. Number of seniors that receive mobile mental health services

1.3 ***Use of Exercise to Increase Mental Wellness in the Community:***

1. Identify senior exercise programs offered
   a. Exercise classes offered in both communities; Condon and Arlington
2. Increase group participation in wellness programs
3. Team with clinics to promote use of fitness center in Condon

MEASURABLE PROJECT OBJECTIVES AND METRIC FOR EXERCISE OPPORTUNITIES:

1) Number of senior exercise programs offered
   a. Number of exercise classes offered in both communities
2) Number of groups participating in wellness programs
   a. Number of total participants
3) Number of senior citizens using fitness center referred by clinics

2. Oral Health Education/Promotion

SPECIFIC PROBLEMS IDENTIFIED:

1. Child oral health
2. Adult oral health

STRATEGIES TO WORK ON ORAL HEALTH EDUCATION/PROMOTION

2.1 ***Child Oral Health***

1. Target child oral health: Outreach at events like the children's fair
   a. Disseminate education and outreach materials on proper oral health practices
   b. Giveaways – little pouch with a tooth brush, tooth paste, and floss
2. Collaborate with Advantage Dental Expanded Practice Dental Hygienists to conduct school-based sealant delivery program; 0-20 years of age
   a. Obtain active consent from parents
   b. Conduct full oral health screenings
   c. Deliver preventive services; sealants and fluoride treatments
   d. Refer to dental services if necessary

MEASURABLE PROJECT OBJECTIVES FOR CHILD ORAL HEALTH:

1) Number of outreach events attended
   a. Number of education and outreach materials disseminated

2) Number of consents distributed
   a. Number of signed consents
3) Number of children who receive dental sealants via school-based oral health program
   a. Number of children referred to dental services
4) Number of children who receive dental services in Gilliam County

2.2 ***Adult Oral Health:***

1. Target adult oral health: Initiate correspondence with South Gilliam Health Center and Mike Desjardin, Dentist, to explore possibility for Advantage Dental to provide services to Medicaid clients
2. Explore implementation of virtual dental home (through Advantage Dental)

MEASURABLE PROJECT *OBJECTIVES AND METRICS* FOR ADULT ORAL HEALTH:

1) Number of Medicaid patients who receive dental services in Gilliam County
2) Number of meetings with Advantage Dental regarding virtual dental home

3. *Patient Centered Primary Care Home (PCPCH)*

SPECIFIC PROBLEMS IDENTIFIED:

1. There are no certified Patient Center Primary Care Homes (PCPCH) in Gilliam County
2. The Eastern Oregon Coordinated Care Organization (EOCCO) is expected to have 100% of its members assigned to a PCPCH by 2018
3. Early Learning Hubs have a quality metric which measures all children 0-6 years old assigned to a provider working in a PCPCH
4. EOCCO and other private payers recognize PCPCH status with enhanced per member per month payments on top of fee-for-service charges

STRATEGIES TO WORK ON PATIENT CENTERED PRIMARY CARE HOME (PCPCH)

3.1 ***Data Review:***

1. Collect data from the EOCCO which delineates the primary care provider (PCP) assignment for all zip codes in Gilliam County
2. Collect data from EOCCO which delineates the primary care provider assignment for all children aged 0-6 years in Gilliam County
3. Work with clinics to determine other payer sources which recognize PCPCH status

MEASURABLE PROJECT OBJECTIVES AND METRICS FOR DATA REVIEW:

1. Number (percentage) of patients in various zip codes assigned to each PCP
2. Number (percentage) of children aged 0-6 years assigned to each PCP
3. Number of meetings with clinic regarding other payer sources
   a. Number of PCPCH-recognized payer sources identified

3.2 ***Leadership Meetings:***

1. Develop relationship with leadership of the North and South Gilliam Health Districts to introduce the concept of PCPCH
2. Offer comprehensive practice management assessment for the North and South Gilliam

Health Districts to determine readiness for PCPCH

3. Provide on-going technical assistance to North and South Gilliam Health District clinics to achieve PCPCH recognition.

MEASURABLE PROJECT OBJECTIVES AND METRICS FOR LEADERSHIP MEETINGS:

1. Number of PCPCH meetings with North and South Gilliam Health Districts
2. Number of comprehensive practice management assessments (or number of clinics)
3. Number of PCPCH-related technical assistance trainings

4. Incentive Measures (IM)

SPECIFIC PROBLEMS IDENTIFIED:

1. Immunizations
2. Developmental screening
3. Adolescent well-care visits for the 12-21 age group

STRATEGIES TO WORK ON INCENTIVE MEASURES

4.1 ***Immunizations Outreach & Education:***

1. Provide educational information on the importance of immunizations and ages of immunizations
    a. Place information in target areas (i.e. libraries, schools, and children's facilities)
2. Collaborate with Healthy Start-Home Visiting & Public Health Nurse Home Visiting programs
3. Collaborate with North Central Public Health WIC clinics
4. Collaborate with the clinics in North and South Gilliam Health Districts

MEASURABLE PROJECT OBJECTIVES AND METRICS FOR INCREASED IMMUNIZATIONS:

1) Number of educational materials disseminated in target areas
2) Number of new participants in Healthy Start-Home Visiting & Public Health Nurse Home Visiting programs
3) Number of meetings with WIC
4) Number of meetings with clinics
5) Number of immunizations given to children and adolescents
    a. Arlington Medical Center
    b. South Gilliam Health Center

4.2 ***Developmental Screening:***

1. Meet with both clinics to discuss possible billing issues (Speak with Paul McGinnis if there are issues to get the correct coding to submit for payment)
2. Collaborate with Early Intervention/Early Childhood Special Education (EI/ECSE) along with North Central Education Services District (NCESD) and the Public Health Nurse – to reach additional children not screened at preschools, WIC clinics and child care facilities
    a. These completed screens can be sent to PCP so that they can schedule follow-up (F/U) appointment with parents to go over screens and receive compensation
3. Communicate with the clinics about partners screenings – make sure they are aware that partners can obtain a release of information from the parents to send screens to PCP

MEASURABLE PROJECT OBJECTIVES AND METRICS FOR DEVELOPMENTAL SCREENINGS:

1) Number of meetings with both clinics regarding developmental screening billing issues
2) Number of partner developmental screenings among children aged 0-36 months sent to PCP (i.e. number of ROIs to PCP from partners)
3) Number of meetings with clinics to increase awareness of ROI from partner screenings and F/U

4.3 ***Expand Sports Physicals to Constitute Adolescent Well-Care Visits for the 12-21 Age Group:***

1. Set up meetings with Arlington Medical Center to discuss differences between current sports physical and adolescent well-care exam.
2. Meet with the schools to inquire about the current Oregon School Activities Association (OSAA) sports physical and changing out or modifying the paperwork to become an adolescent well-care exam.

MEASURABLE PROJECT OBJECTIVES AND METRICS FOR INCREASING ADOLESCENT WELL-CARE VISITS FOR THE 12-21 AGE GROUP:

1) Number of adolescent well-care visits for children 12-21 years of age
2) Number of adolescent well-care visits for 12-21 age groups that would have been just a sport physical